PRINTED: 09/29/2011 FORM APPROVED

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES				ON	MB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMP	LETED
		155756	B. WIN			08/26/2	2011
NAME OF	DROLLIDED OF GUIDNI H				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	EK		7843 W	/ JEFFERSON BLVD		
COVEN	TRY MEADOWS			FORT \	WAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0000							
	İ		FO	0000	The creation and submission		1
	This visit was	for Recertification and			this Plan of Correction does		
	State Licensu	re Survey.			constitute an admission by		
		,			provider of any conclusion forth in the statement of	sei	
	Survey Dates	: August 22, 23, 24, 25,			deficiencies, or of any viola	tion of	
	26, 2011				regulation.		
	Facility Numb	er: 004945			This provider respectfully requests that the 2567 Plar	o of	
	Provider Num				Correction be considered the		
	AIM Number:	200814400			Letter of Credible Allegation	-	
					Due to relative low scope a		
	Survey Team:				severity of this survey, this		
	Sheryl Roth R				respectfully requests a des		
	Rick Blain RN				review in lieu of a post-surv revisit on or after Septembe		
	Sue Brooker F				2011.	51 20,	
	Diane Nilson I						
	Angie Strass I						
	7 trigic Ottass i	1 (1 4					
	Census Bed T	Type:					
	SNF: 31	) I					
	SNF/NF: 110						
	Total: 141						
	10.0						
	Census Payor	r Type:					
	Medicare: 30	* ·					
	Medicaid: 75						
	Other: 36						
	Total: 141						
	Stage 2 Samp	ole: 40					
	These deficie	ncies reflect state					

findings cited in accordance with 410 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1PQP11

Facility ID:

004945

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155756	B. WING			08/26/2	011
			D. WILL		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER				/ JEFFERSON BLVD		
COVENT	RY MEADOWS		FORT WAYNE, IN46804				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	IAC 16.2.						
F0223 SS=A	Williams, RN The resident has t verbal, sexual, phy	9/02/11 by Suzanne he right to be free from ysical, and mental abuse, ent, and involuntary					
	sexual, or physica punishment, or inv Based on interv the facility failed abuse of reside affected 1 of 3	roluntary seclusion.  View and record review,  It to prevent verbal  Ent from staff. This  Tresidents reviewed for  The most on met the criteria for	F0.	223	F 223 Abuse  It is the practice of thi facility to protect all resident from verbal abuse of staff. However, based on the alleg deficient practice the followi has been implemented:	s ged	09/24/2011
	Resident #13 of indicated the for included, but we depression, send depressive features, and A family member interviewed on During the interstaff were speat at Resident #13 of indicated the formula in the interviewed on the interviewed of the interviewed at Resident #13 of indicated the formula includes the interviewed on the interviewed of the intervie	clinical record for n 8/24/11 at 9:42 a.m., ollowing: diagnoses ere not limited to, nile dementia with tures, delusional lizheimer's disease.  er of Resident #13 was 8/23/11 at 2:51 p.m. rview she indicated liking loudly and yelling 3. She also indicated ed to the facility.			What corrective action(s) we accomplished for those residents found to have be affected by the deficient practice:  Resident #13 was evaluated by SSW for any signs/symptoms of psychos harm and none were noted. CNA #7 was immedia suspended and terminated following investigation.  How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be ta	en ocial tely tial	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DDIC	00	COMPL	LETED
		155756	B. WING			08/26/2	011
			D. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	1			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN46804		
COVENT	KT WEADOWS			FORTV	VATNE, IN40804		
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A Facility Incide	ent Reporting Form,					
	dated 4/27/11,	indicated at					
	approximately (	6:30 p.m., the charge			· No other residents we	-	
		king down the 400 hall			found to have been affected the alleged deficient practice	•	
	and was passir	_			· All residents have pote		
	•	Resident #13 was			to be affected by the deficier		
					practice.		
	heard to ask Co	•			•		
	,	A) #7 a question to					
		responded she was					
		e roommate. Resident			What measures will be put	into	
	#13 responded	to CNA #7 she doesn't			place or what systemic		
	give a damn, to	which CNA #7			changes you will make to		
	responded in a	loud rude tone of			ensure that the deficient		
	voice "I don't gi	ive a damn either."			practice does not recur:		
	The incident wa				· Staff Development		
		ne CNA was suspended			Coordinator in-services all no	ew	
	-	estigation. Resident			employees on abuse; Annua		
		nysician and Director of			Mandatory Training is done;		
					in-services after any alleged		
	_	otified. Resident #13			event.		
		nate were evaluated			· All Managers are		
		for any signs of			responsible to oversee		
	psychosocial h	arm. CNA #7 was			compliance.		
	terminated.						
	A Social Servic	e Progress Note for			How the corrective action(s	3)	
	Resident #13, o	_			will be monitored to ensure	•	
		es (resident) noted by			deficient practice will not re		
		Director) to have been			i.e., what quality assurance		
	,	ent reported to state.			program will be put into pla	ace:	
		-					
		gative psychosocial			· A CQI monitoring tool		
	issues noted				called Abuse Prohibition and		
					Investigation will be utilized a	every	
	A Social Servic	e Progress Note for			week x 4, monthly x 3 and quarterly thereafter.		
	Resident #13, o	dated 4/29/11,			· Data will be collected	bv	
	indicated " Re	es talking w/ (with) her			Data will be collected	~ y	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155756	B. WIN	IG		08/26/2011
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	JEFFERSON BLVD	
COVENT	RY MEADOWS			FORT V	VAYNE, IN46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	•	parent mood or			Executive Director/Designee 1 st , 2 nd , and 3 rd shifts a	
	psychosocial o	utcomes noted"			submitted to the CQI Commi	
					If threshold is not met, an ac	ı
	The facility Adn				plan will be developed.	
	interviewed on	8/25/11 at 3:06 p.m.			All staff was in-service	ı
	During the inter	rview he indicated the			signs and symptoms of staff	burn
	facility had zero	tolerance for abuse			out that may result in verbal abuse by Staff Development	
	toward resident	ts.			Coordinator.	
					· Staff Development	
	A current facilit	y policy "Abuse			Coordinator in-services all ne	* * *
	Prohibition, Re	porting, and			employees on abuse; Annua	
	Investigation",	dated February 2010,			Mandatory Training is done; in-services after any alleged	and
	indicated "It is	s the policyto protect			event.	
	residents from	abuseverbal			OVOIN.	
	abusedefined	l as the use of oral,				
		ured language that			Compliance date: 9/24/201	1
	_	s disparaging and				
	•	ns to residentsor				
	within their hea					
		neir age, ability to				
	comprehend, o	• •				
	3.1-27(b)					
	<i></i> ( <i>0</i> )					

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155756	A. BUIL B. WING			08/26/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0278 SS=D	The assessment r resident's status.	must accurately reflect the					
	each assessment participation of he	e must conduct or coordinate with the appropriate alth professionals.					
	the assessment is	completed.					
	the assessment m	no completes a portion of nust sign and certify the ortion of the assessment.					
	who willfully and k and false stateme is subject to a civil than \$1,000 for ea individual who will another individual false statement in	and Medicaid, an individual chowingly certifies a material int in a resident assessment I money penalty of not more ach assessment; or an ifully and knowingly causes to certify a material and a resident assessment is noney penalty of not more ach assessment.					
	Clinical disagreem material and false	nent does not constitute a statement.					
	and interview, to ensure the Min Assessment was of motion and I than six months reviewed for as stage 2 sample Findings include	ervation, record review the facility failed to imum Data Set (MDS) as accurate for range ife expectancy of less is for 1 of 40 residents in the e of 40. (Resident #53) le:  at 9:45 a.m., Resident	F0	278	F 278 Assessment Accuracy/Coordination/Cer d It is the practice of this faci ensure that the Minimum Dar Set (MDS) Assessment is accurately completed for ran motion and life expectancy o than 6 months for applicable residents. However, based o alleged deficient practice the following has been implemer What corrective action(s) w be accomplished for those residents found to have been	lity to ta ge of f less n the nted: vill	09/24/2011
	1. On 0/2 <del>-/</del> /11	at o. to a.m., resident			affected by the deficient		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	LDDIC	00	COMPLE	ETED
		155756		LDING		08/26/20	)11
		1	B. WIN		DDDEGG CHTV GTATE TID GODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	JEFFERSON BLVD		
COVENT	TRY MEADOWS			FORT	VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#53 was obser	ved sitting in the			practice: Resident #53's N	-	
	lounge with mu	ısic playing, asleep.			has been corrected to reflect		
	Bilateral hands	s of Resident #53 were			impairment of resident's Ran	- 1	
	closed into a fi				Motion. Resident #53's init		
		ot.			diagnosis for requiring hospi		
	0 - 0/05/44 -1	44.45 a.m. Daablant			services was brought forward		
		11:15 a.m., Resident			reflecting diagnosis supportir terminal decline that was	'9	
		ved sitting in a comfort			Advanced Dementia. <b>How v</b>	vill	
	chair in his roo	m. LPN #10 attempted			you identify other residents	····	
	to open Reside	ent #53's closed fisted			having the potential to be	´	
	hands. The re	sident grimaced and			affected by the same deficient	ent	
		d the nurse was barely			practice and what correctiv		
		is hands enough to put			action will be taken: No o		
		•			residents were found to have		
		ne palm of his hands.			been affected by the alleged		
					deficient practice. · Residen		
	The clinical red	cord for Resident #53			with chronic progressive dise	ease	
	was reviewed	on 8/24/11 at 10:30			with increased debilitation ha	ave	
	a.m. Diagnose	es included, but were			the potential to be affected b	y the	
		eft hip fracture, polio,			alleged deficient practice.		
	and fractured l	•			Therapy will evaluate resider		
		cit silodider.			admission and on a quarterly		
	The UT-	dath and Theorem			basis. Findings will be relaye		
		ciplinary Therapy			MDS Coordinator · MDS wil	i be	
		ted 2/9/11, indicated			updated by therapy via Therapy-to-MDS communica	tion	
	Resident #53 h	nad impaired range of			form to reflect resident's curr		
	motion.				Range Of Motion function.	- I	
					Residents qualifying for hosp	oice	
	The MDS asse	essment dated 2/22/11,			care will have qualifying diag		
	indicated Resid				indicated on MDS. In-servi		
					was done September 9, 201		
	1 -	range of motion on both			MDS Coordinator. MDS		
	sides of his upper extremities and on				Coordinator/Designee and N		
	one side of his	lower extremities.			Management are responsible	e for	
					overseeing compliance. ·		
	The MDS dated 4/20/11, indicated				Resident #53 has a clarificat		
	Resident #53 had no impairment in			order stating diagnosis of en			
		•			stage dementia and MDS wil	ll be	
		n of either upper or			updated at next quarterly		
	lower extremiti	es.	1		assessment in October of 20	)11. •	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155756	1			08/26/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
00\(ENI				1	JEFFERSON BLVD		
COVEN	TRY MEADOWS			FORT	VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					Resident #53 care plan has I	been	
	The "Transdisc	ciplinary Therapy			updated to reflect diagnosis		
		6/29/11, indicated			end stage dementia. · Resid		
					#53 MDS has been modified		
		nad impaired range of			reflect impairment with Rang		
	motion.				Motion to both hands. · Res		
					#53 resident care sheet and		
	The "Hospice (	Care Plan," dated			plan have been updated to re		
	· ·	ted Resident #53's			impairment with Range of Mo		
	1 '	ested patient be			to both hands. What measur		
		thout pain and have his			will be put into place or who	at	
		-			systemic changes will you		
		ds washed out and			make to ensure that the		
	nails trimmed a	and cleaned.			deficient practice does not		
					recur: Therapy will evaluate residents on admission and of		
	The Transdisci	plinary Therapy			quarterly basis. Findings will		
		ed 7/12/11, indicated a			relayed to MDS Coordinator		
		ssment was completed			MDS will be updated by there		
		-			via Therapy-to-MDS	дру	
	1 '	I Therapist. The report			communication form to reflect	et	
		dent #53 had impaired			resident's current Range Of		
	1	n and was at risk for			Motion function. · Residents		
	skin breakdow	n, poor hygiene, or			qualifying for hospice care w	ill	
	pain.				have qualifying diagnosis		
					indicated on MDS. · In-servi		
	The MDS date	d 7/12/11, indicated			was done September 9, 201	1 by	
		nad no impairment in			MDS Coordinator. · MDS		
		•			Coordinator/Designee and N		
		n of either upper or			Management are responsible	e for	
	lower extremiti	es.			overseeing compliance.	ion	
					Resident #53 has a clarificat order stating diagnosis of en		
	The instruction	s for coding the			stage dementia and MDS wil		
	functional limita	ation in range of motion			updated at next quarterly	. 50	
	on the MDS was provided by MDS				assessment in October of 20	)11. ·	
	Nurse #1 on 8/26/11 at 8:38 a.m. The				Resident #53 care plan has I		
	instructions indicated the intent was to				updated to reflect diagnosis		
					end stage dementia. Resid		
	determine whe				#53 MDS has been modified		
		nge of motion (ROM)			reflect impairment with Rang		
	interfered with	the resident's activities			Motion to both hands. · Res	ident	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155756 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7843 W JEFFERSON BLVD **COVENTRY MEADOWS** FORT WAYNE, IN46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE of daily living or places him or her at #53 resident care sheet and care plan have been updated to reflect risk of injury. impairment with Range of Motion to both hands. · MDS An interview was conducted with LPN Coordinator and Rehabilitation #10 on 8/24/11 at 10:35 a.m. During Service Manager will in-service all therapy staff and restorative aides the interview, the LPN indicated on Communication Form, Range Resident #53 had contractures to of Motion evaluation. In-service bilateral hands and arms. She further will be completed by September indicated the resident in the past used 24. 2011. Residents being admitted to hospice services will carrots (carrot shaped device for have the current diagnosis for hands) and wash cloths in his hands qualifying illness brought forward for the contractures but the resident to the MDS. This will be reviewed did not like them and would grimace by the Nurse Managers in the with their use. Morning Meeting. In-service on this procedure was done by DNS with Nurse Managers on An interview was conducted with MDS September 8, 2011. How the Nurse #1 on 8/24/11 at 11:15 a.m. corrective action(s) will be During the interview, she indicated monitored to ensure the she obtains information for completing deficient practice will not recur, the MDS from therapy, care sheets, i.e., what quality assurance program will be put into place: etc. She further indicated Resident · A CQI monitoring tool called #53 was dependant for care so this MDS Diagnosis which includes couldn't affect his daily care so she Range of Motion and end of life did not mark the MDS with decreased diagnosis will be utilized every range of motion. week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from During an interview on 8/24/11 at 3:31 1 st and 2 nd shifts and submitted p.m. with Resident #53's daughter, to the CQI committee. If she indicated he has contracted threshold is not met, an action hands that have to be physically plan will be developed. · Non-compliance with facility opened by staff in order to clean procedures may result in them. She also indicated the disciplinary action up to and resident's left hand had been including termination. contracted for 3 or 4 years and after a Completion small stroke, the right hand developed

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155756			A. BUILD	DING	NSTRUCTION  00	(X3) DATE S COMPL <b>08/26/2</b> (	ETED
	PROVIDER OR SUPPLIER			STREET AI	DDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD /AYNE, IN46804	00/20/2	
					ATINE, IN40004		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	contractures.				Date: 9/24/20	11	
	7/12/11, indicated not have a condisease that may expectancy of live. The MDS 7/12/11 indicated receiving hospical transport of: general decindicated Residual hospice services.  The "Nursing Farabout Hospice Election of the Pospice Election of th	Resident is receiving es related to diagnosis cline," dated 4/21/11, lent #53 was receiving es acility Resident on Notification," dated ed Resident #53 had a					
F0282 SS=D	3.1-31(d) The services provifacility must be proin accordance with plan of care. Based on obse and interview, to follow the care during meals, for residents review.	ded or arranged by the ovided by qualified persons a each resident's written arvation, record review, he facility failed to plan for back support for 1 resident of 40 wed for care plans in apple of 40. (Resident	F02	82	F 282 Services by Qualified Persons/Per Care Plan It is the practice of this facility ensure that each resident's individualized care plan is updated to reflect the current physician orders. However, to on the alleged deficient pract the following has been implemented:	y to	09/24/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155756	B. WING		08/26/2011	
				ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER		7843	W JEFFERSON BLVD		
COVENT	RY MEADOWS		I	T WAYNE, IN46804		
(X4) ID	SHWWADVS	TATEMENT OF DEFICIENCIES	ID ID	_ <b>T</b>	(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	' '	N
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE	•
	Findings includ		-			
	i indings includ	<b>C</b> .				
	The clinical rec	ord for Resident #53		What corrective action(s)	will	
				be accomplished for thos	e	
		on 8/24/11 at 10:30		residents found to have b	een	
	•	s included, but were		affected by the deficient		
		eft hip fracture, polio,		practice:		
	fractured left sh	•				
	Alzheimer's der	mentia.		Resident #53's care	plan	
				and resident care sheet accurately reflects current		
	The "Physician	's Orders/Plan of		physician's orders for posit	ioning	
	Care," dated 7/	10/11, indicated		priyalciaria ordera for positi	.ioriii ig.	
		tilized a lumbar				
	support pillow.			How will you identify other	er	
	oupport pillott.			residents having the pote	ntial	
	On 9/22/11 at 1	2:00 n m Posidont		to be affected by the sam	e	
		2:00 p.m., Resident		deficient practice and wh		
		ved in the assist dining		corrective action will be t	aken:	
		ort chair. No back				
	cushion was ob	served in the chair.		No other residents v  found to have been affects.		
				found to have been affecte the alleged deficient practi	• 1	
		1:26 a.m., Resident		· Resident care plans		
	#53 was observ	ved in the assist dining		reviewed with the resident	<b> </b>	
	room in a comf	ort chair. No back		sheets on ongoing basis w	ith	
	cushion was ob	served in the chair.		Care Plan Team after Morr	· 1	
				Meeting to assure continui	-	
	On 8/25/11 at 1	1:30 a.m., Resident		resident care per physiciar	1	
		ved in the assist dining		orders.  Care Plan Team was		
		ort chair. No back		educated on process by Al		
		served in the chair.		September 9, 2011.		
	Jackholi Was Ob	.cc. voa in the onair.		· ADNS/Designee is		
	On 8/26/11 at 1	2:00 n m Pesident		responsible to oversee		
		2:00 p.m., Resident		compliance.		
		ved in the assist dining		· All care plans will be		
		ort chair. No back		reviewed by September 24	<b> </b>	
	cushion was ob	served in the chair.		to ensure physician orders adaptive equipment are follows:		
				adaptive equipment are to	iowed.	
	The current CN	IA assignment sheet				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ONSTRUCTION 00	(X3) DATE S COMPL	
		155756	A. BUI B. WIN	LDING G		08/26/2	011
	PROVIDER OR SUPPLIER		<u> </u>	7843 W	ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON BLVD WAYNE, IN46804	1	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC INCRETEVING DIFFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY	ΤE	(X5) COMPLETION
TAG	was provided by assignment she was to be place Resident #53 for eating.  On 8/24/11 at 1 Aide #12 was 0 #53's cushions.	y MDS Nurse #1. The eet indicated a pillow ed behind the back of or positioning when  1:26 a.m., Hospice queried on Resident . The aide pointed to n as being the only of the chair.		TAG	What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur  ADNS/Designee will residents care sheets daily call current residents are completed. Resident care sheets be updated by ADNS/Design during morning meeting as physician orders are read arreviewed by IDT. The Staff Developmer Coordinator/Designee will in-service Interdisciplinary Toby September 24, 2011.  How the corrective action(swill be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plates. A CQI monitoring tool called Resident Care Sheet be utilized every week x 4, monthly x 3 and quarterly x 2. Data will be collected DNS/Designee from 1 st and shifts submitted to the CQI committee. If threshold is met, an action plan will be developed. Non-compliance with factoric procedures may result in disciplinary action up to and including termination.	eview until will nee and s) e the ecur, e ace: will 2. by d 2 nd not cility	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		A. BUILDING 00 CC 08/				COMPLETED 8/26/2011	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7843 W JEFFERSON BLVD FORT WAYNE, IN46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0325 SS=D	assessment, the faresident - (1) Maintains accentritional status, sprotein levels, unlescondition demonstrates possible; and (2) Receives a thean utritional problet Based on obseand interview, the prevent weight with weight loss criteria for nutritional receives and interview of the clinical receives reviewed of Diagnoses included as reviewed o	rvation, record review he facility failed to loss in 1 of 8 residents is of 22 who met the tion. (Resident #82) e: ord for Resident #82 on 8/22/11 at 2:00 p.m. uded, but were not hia, dementia, ession, and aphasia king). or at risk for adverse or low blood sugar, indicated "diet as or intakes and offer or less than 75%	F0:	325	F 325 Maintain Nutrition State Unless Unavoidable It is the practice of this facility to propappropriate nutritional status avoid weight loss in resident dependent upon staff for fee However, based on the alleg deficient practice the following has been implemented:  What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice: Resident #82 is Nutrition At Risk watch list for weekly weight. Resident #Care Plan is current with nutritional risk status. All Sinvolved in resident meal ser including but not limited to nursing and dietary staff, will in-serviced on timeliness of feeding once meal service begins. In-service will be conducted by Staff Developr Coordinator/Designee by September 24, 2011. How we	atus emote to s ding. ged ng  vill en on vr 82's staff rvice	09/24/2011

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	LETED
		155756	B. WIN			08/26/2	011
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			/ JEFFERSON BLVD		
COVEN	TRY MEADOWS			1	VAYNE, IN46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	+	TAG	· · · · · · · · · · · · · · · · · · ·		DATE
	1	indicated the following:			you identify other resident	:S	
		ghtoffer substitute is			having the potential to be affected by the same defice	iont	
	<75% of any n	neal is consumed"			practice and what correcti		
	There was no	current care plan for			action will be taken: No		
	weight loss.				residents were found to have		
					been affected by the allege		
	The "Dietary P	rogress Notes," dated			deficient practice. All resid		
	1	ited Resident #82 was			with gradual weight loss an	d	
	1	reed diet with nectar			dependent upon staff for		
		nd the resident was fed			nutritional intake could pote	•	
		nu the resident was led			be at risk. · Meal consump		
	by staff.				records will be monitored by Nurse Managers on daily be		
	l				Weights will be monitored b		
	•	for mechanically			NAR committee on weekly		
	altered diet, da	ated 7/11/11, indicated			What measures will be put		
	the resident ha	ad a history of chewing			place or what systemic		
	and swallowing	g difficulties and was			changes you will make to		
	fed by staff at	all meals.			ensure that the deficient		
					practice does not recur: ·		
	The "Weight V	ariance Report," dated			Resident's consuming less	than	
	1	1, listed the following			75% of meal will be offered		
	weights for Re				replacement · All resident's		
	1 -				having gradual weight decli have care plan addressing	ne wiii	
	8/1/11 - 130 pc				current interventions. · All		
	7/1/11 - 133 pc				resident's requiring staff		
	6/1/11 - 135 pc				assistance with meal		
	5/1/11 - 138 pc				consumption will be fed time	ely. ·	
	4/1/11 - 140 pc	ounds			Resident meal intake will be		
	3/1/11 - 142 pc	ounds			documented correctly to ref		
	2/1/11 - 140 pc	ounds			the accurate amount consu	med.	
	1/1/11 - 142 pc	ounds			Staff Development     Coordinator/Designed will not be a second to the second to	rovid-	
	1				Coordinator/Designee will p in-service training to all staf		
	On 8/25/11 at	11:30 a.m., Resident			assisting with meal service		
		rved in the assist dining			Nutrition At Risk (NAR) mer		
					by September 24, 2011.		
		. The food cart arrived			In-service will include but no	ot	
	1	oom at 11:53 a.m., and			limited to accurate docume	ntation	
	the following w	vas observed:					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155756	B. WIN	\G		08/26/2	011
NAME OF	DD OLUDED OD GUDDUIEI	`	!	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER	C		7843 W	JEFFERSON BLVD		
COVEN	TRY MEADOWS			FORT V	VAYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	11:54 a.m., Re	sident #82's food was			and knowing how to encoura	-	
	placed in front	of him and uncovered.			residents to eat at all three n	neals.	
	His lunch inclu	ded 3 nosey cups of			<ul> <li>Staff Development Coordinator/Designee will pr</li> </ul>	ovido	
	beverages.	• •			in-service training to all dinir		
	_	ablemate took a bite of			room managers by Septemb	-	
		mashed potatoes and			24, 2011. In-service will incl		
		ew potatoes from the			but not limited to accurate		
	kitchen.	ew potatoes from the			documentation and knowing		
		sident #82 reaching			to encourage residents to ea	ıt,	
		_			monitoring consumption,	ا ما	
	and grabbing a				including all dining rooms ar three meals. · NAR committ		
	1	alified Medication Aide			responsible for overseeing	CC IS	
	1 '	red the dining room to			compliance. Staff will be		
		t #82 and the rest of			monitored by dining room		
	his tablemates	with lunch.			managers to ensure staff is		
	12:02 p.m., QN	/IA #8 sat down to			providing necessary assista	nce to	
	assist with lund	ch.			residents. Meal		
	12:03 p.m., Re	sident #82 grabbed at			consumption records will be		
		nocked off a glass of			monitored by nurse manage daily basis and includes a pa		
	1	was never replaced.			review in conjunction with di		
	1 -	started to clean up the			observation by the dining roo		
	spilled juice.	marted to erearr up the			manager/Designee compari		
	1 ' '	sident #82 still waiting			documentation with actual		
		d reaching for food.			observations to ensure the		
		•			documentation is accurate. I		
	1 '	sident #82 received his			the corrective action(s) will	pe	
		d thirteen minutes after			monitored to ensure the		
		vered and uncovered.			deficient practice will not re i.e., what quality assurance		
		ceived a bite of food			program will be put into pla		
	12:10 p.m., red	ceived a bite and a			· A CQI monitoring tool calle		
	drink				Meal Consumption will be ut		
	12:12 p.m., red	ceived a bite of food			every week x 4, monthly x 3		
	12:13 p.m., red	ceived a bite of food			quarterly x 2. The CQI tool		
		eived a bite of food			includes a paper review in		
		eived a bite of food			conjunction with direct		
	1	ceived a bite of food			observation by the dining roo		
		ceived a sip of his drink			manager/Designee comparing documentation with actual	ıy	
	_ 1∠.∠5 ρ.π., rec	erved a sip or his drink			documentation with actual		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		A. BUIL	DING	NSTRUCTION  00	(X3) DATE S COMPL 08/26/20	ETED	
	OVIDER OR SUPPLIER		B. WINC	STREET A	DDRESS, CITY, STATE, ZIP CODE  JEFFERSON BLVD  VAYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:27 p.m., record and a sip of his 12:28 p.m., record 12:29 p.m., record 12:30 p.m., record 12:31 p.m., the out towards his his 15th bite of his drink 12:35 p.m., resistan 50% of lur 12:37 a.m., all sidone feeding retake all resident The "Food/Fluic dated August 20 #82 as having of lunch on 8/25/1 An interview wa #8 on 8/26/11 at the interview, side #82 at a about 50 lunch on 8/25/1 liquids. She fur sleepy and she him up. She also	eived a bite of food eived a bite of food eived a bite of food eived a bite of his drink resident was reaching food, he then received food and his 5th sip of dent consumed less ich. estaff in dining room esidents and starting to its back to their rooms.  d Intake Record,", 011, listed Resident consumed 100% of			observations to ensure the documentation is accurate. will be collected by DNS/Designee from 1 st and shifts and submitted to the Committee. If threshold is not met, an action plan will be developed. Non-compliant with facility procedures may in disciplinary action up to an including termination.  Completion date: 9/24/201	2 nd QI ot se result nd	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155756	B. WING		08/26/2011
NAME OF F	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE  JEFFERSON BLVD	
COVENT	RY MEADOWS			VAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
F0356 SS=C	The facility must p on a daily basis: o Facility name. o The current date o The total numbe worked by the folloand unlicensed nu responsible for research or a cocational nurses law).  - Certified nurse o Resident census The facility must p specified above or beginning of each as follows: o Clear and reada o In a prominent p residents and visit The facility must, u make nurse staffin public for review a community standa The facility must m nurse staffing data months, or as requisited and unlicensed on 1 of 5 days of the potential to	ost the following information  a.  r and the actual hours owing categories of licensed rsing staff directly sident care per shift: urses. ctical nurses or licensed (as defined under State  se aides. a.  ost the nurse staffing data in a daily basis at the shift. Data must be posted  ble format. lace readily accessible to ors.  upon oral or written request, g data available to the t a cost not to exceed the rd.  maintain the posted daily in for a minimum of 18 uired by State law,	F0356	F 356 Posted Nurse Staffing It is the practice of this facilit post daily the licensed and unlicensed nurse staffing hor The following has been implemented:	g 09/24/2011 y to

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155756	B. WIN			08/26/2	011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	JEFFERSON BLVD		
COVENT	RY MEADOWS			1	VAYNE, IN46804		
	INT WILADOVVO			L	VATIVE, 11440004		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
					What corrective action(s) w	ʻill	
	Findings includ	le:			be accomplished for those		
					residents found to have be		
	1. During the i	nitial tour of the facility,			affected by the deficient		
	_	25 a.m., on 8/22/11,			practice:		
					The daily staffing patte	arn	
	the nurse staffing hours were observed posted in a glass case on				will be posted on a daily bas		
	•	<u> </u>			guidelines.	- poi	
	the wall, on 50						
		per of hours for licensed					
		staff were posted,			How will you identify other		
	however, the s	taffing form was dated			residents having the potent	tial	
	8/8/11.				to be affected by the same		
					deficient practice and what		
	The Director of	Nursing Services			corrective action will be tak	en	
		terviewed, at 8:20 a.m.,					
	, ,	d indicated QMA # 8			· The Nurses		
					Scheduler/Designee will pos		
	•	le for posting the			staffing pattern daily and Nui Supervisors will update at	se	
	•	but had been on			beginning of shift.		
		no one was assigned			· All residents have the		
	to post the staf	fing hours while she			potential to be effected by th		
	was on vacation	n.			alleged deficient practice.		
	The DNS was	interviewed, at 12:30					
		1, and indicated the			What measures will be put	into	
	' '	nave a policy for			place or what systemic		
	•	-			changes you will make to		
	posting the sta	illing flours.			ensure that the deficient		
	0.4.40( )				practice does not recur		
	3.1-13(a)				Re-training of Nurse	daans	
					Scheduler and Nurse Superv		
					was done on September 9, 2 by Director of Nursing Service		
					The Director of Social		
					Services will check to ensure		
					updated due to the office loc		
					is directly across the hall from		
					posting site.		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/26/2011
		100700	B. WING	ADDRESS SITE STATE STREET	06/26/2011
NAME OF P	ROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE  V JEFFERSON BLVD	
COVENT	RY MEADOWS			WAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
mo	REGULTION	Esc ISENTE FING IN ORGANICALLY	mo	Director of Nursing     Services is responsible to     oversee compliance.	Diff
				How the corrective action(s) will be monitored to ensure deficient practice will not r i.e., what quality assurance program will be put into plate  A CQI monitoring tool called Nurse Schedule will be utilized every week x 4, mor 3 and quarterly x 2.  Data will be collected DNS/Designee from 1 st and shifts and submitted to the C committee. If threshold is no met, an action plan will be developed.  Non-compliance with fac procedures may result in disciplinary action up to and including termination.	e the ecur, e ace:  De nthly x  by d 2 nd CQI ot  Cility
				Completion date: 9/24/201	1
F0371 SS=E	considered satisfal local authorities; a (2) Store, prepare under sanitary cor Based on obseand interview, twash hands for amount of time	, distribute and serve food	F0371	F 371 Food Procure, Store/Prepare/Serve-Sanita It is the practice of this facilit store, prepare, distribute and serve food under sanitary conditions. However based	09/24/2011 ary ty to d

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	I DINC	00	COMPL	ETED
		155756	B. WIN	LDING IG		08/26/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R		1	JEFFERSON BLVD		
COVEN	TRY MEADOWS			1	VAYNE, IN46804		
				L	VATIVE, INTOOOT		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION)		TAG	,		DATE
	1 -	erages served to			alleged deficient practice the		
	residents with	out touching the			following has been impleme	ntea.	
	drinking rims of	of the glasses, and feed					
	finger foods to	residents without the					
	use of bare hands potentially affecting 91 residents who ate their meals in 3 of 5 dining rooms of 141 residents				What corrective action(s) v	vill	
					be accomplished for those		
					residents found to have be		
	residing in the				affected by the deficient		
					practice.		
	Findings include	de.			5		
	T manigo moia				<ul> <li>Dietary Manager/Des will in-service all staff assist</li> </ul>		
	1 On 8/22/11	at 12:10 p.m., CNA #13			with meal service. Education	•	
	1				training will include but not I		
		to pick up a fork off of			to proper hand washing		
		e performing a six			procedure, proper handling	of	
	1	vash, directly under the			glasses when delivering liqu	ıids,	
	1	ssist dining room before			and proper way to assist		
	continuing to p	bass trays to residents.			residents with finger foods.		
	QMA #8 was o	bserved on 8/22/11 at			How will you identify other		
	11:34 a.m. per	forming a 6 second			residents having the poter		
	hand wash after	er repositioning a			to be affected by the same		
	resident.				deficient practice and wha		
					corrective action will be ta		
	On 8/22/11 at	12:03 p.m., QMA #8					
	1	cleaning up spilled			· All residents receiving	•	
	1	floor of the assist dining			fluids and finger foods at me		
	1 *	wash her hands for 4			time has potential to be affe	cted	
					by practice.  Dietary Manager/Des	ianee	
		e assisting Resident			will in-service all staff assist		
	#27 with putting her clothing protector on. After that, the QMA used hand sanitizer and sat down to feed residents.				with meal service. Education		
					training will include but not l		
					to proper hand washing		
					procedure, proper handling		
					glasses when delivering liqu	ıids,	
	On 8/22/11 at	12:23 p.m., QMA #8			and proper way to assist residents with finger foods.		
	was observed	to pull a resident up in			residents with iniger 1000s.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155756 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7843 W JEFFERSON BLVD **COVENTRY MEADOWS** FORT WAYNE, IN46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE her chair and then perform a 10 In-service training on hand washing with return second hand wash. demonstration, and proper handling of tableware will be 2. QMA #8 was observed pick up a completed by September 24, french fry with her bare hands and 2011 by Dietary Manager. feed to Resident #27 on 8/22/11 at Dining Room Managers are responsible to oversee 12:08 p.m., 12:09 p.m., 12:11 p.m. compliance in all dining rooms and all three meals including the On 8/22/11 at 12:13 p.m. and 12:16 Memory Care Facilitator p.m., LPN #10 was observed to pick overseeing compliance in the up a french fry with her bare hands Memory Care dining room. and feed to Resident #27. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Dietary Manager/Designee will in-service all staff assisting with meal service. Education and training will include but not limited to proper hand washing procedure, proper handling of glasses when delivering liquids, and proper way to assist residents with finger foods. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A CQI monitoring tool called Sanitary Conditions will be utilized every week x 4, monthly x 3 and quarterly x 2.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155756	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 08/26/2011
	PROVIDER OR SUPPLIER		STREET / 7843 W	ADDRESS, CITY, STATE, ZIP CODE  / JEFFERSON BLVD  // JEFFERSON BLVD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	meal in the Me 8/22/11 at 11:5 were in the dinitables ready for Unit staff were beverages prior steam table. Chassistant (CNA do the following was observed siguice to two results by placing the gand carrying the table by placing fingers inside the fingers to the glasses, and to rims of the glass CNA #3 was observed the glasses of water dining table in the 12:03 p.m., she serve two glasses.	bservation of the lunch mory Care Unit on 5 a.m., all residents ing room and seated at r lunch. Memory Care observed passing r to the delivery of the certified Nursing a) #3 was observed to g: at 11:59 a.m. she serving two glasses of idents at a dining table glasses side by side e glasses to the dining g her thumb and he glasses, pressing he inside of the suching the drinking ises; at 12:00 p.m., oserved to serve two er to two residents at a the same manner; at e was observed to ses of water and three to three residents at a		Data will be collected DNS/Designee from 1 st ar shifts and submitted to the committee. If threshold is met, an action plan will be developed.  Non-compliance with facility procedures may rest disciplinary action up to an including termination.  Completion date: 9/24/20	nd 2 nd CQI not  ult in

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756			LDING	NSTRUCTION  00	(X3) DATE S COMPL <b>08/26/2</b>	ETED	
	PROVIDER OR SUPPLIEF	<u> </u>	p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE JUST JEFFERSON BLVD VAYNE, IN46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:04 p.m., she serve two glasses of milk in the same map.m., she was glasses of water dining table in residents were the glasses.  3. During an obmeal in the Me	the same manner; at e was observed to ses of juice, two, and a glass of water anner., and at 12:05 observed to serve two er to two residents at a the same manner. The observed to drink from					
	observed to ca chocolate milk seated at a din one glass in or glasses in the the two glasses placing her ope drinking rims o them together the rims. At 12 observed to ca	5 a.m., CNA #4 was rry three glasses of to three residents ing table. She carried he hand and two other hand by placing as side-by-side and en palm over the f the glasses to hold with her palm touching 100 p.m., CNA #4 was rry three glasses of ree residents seated at					
	a dining table. glasses in one glasses in the the two glasses placing her ope drinking rims o	She carried one hand and carried two other hand by placing is side-by-side and en palm over the f the glasses to hold with her palm touching					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155756	B. WIN			08/26/2	011
	PROVIDER OR SUPPLIER		'	7843 W	NDDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD VAYNE, IN46804	•	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed to dri	nk from the glasses.					
	During an obsedining room at was observed to #13's cookie and cookie with her Resident #13 at 8/26/11 at 9: interview she in glasses should touching the ring staff should not residents with to the A current facility Preparation and 4/11, indicated cups, glasses, a way as to avoid with which food	rvation of the main 12:25 p.m., LPN #5 o cut up Resident ad feed her bites of bare fingers which ccepted and ate.  mager was interviewed 10 a.m. During the adicated drinking not be handled by as. She also indicated touch food fed to heir bare hands.  y policy "General Food d Handling", revised on "Handle utensils, and dishes in such a I touching surfaces or drink will come into hands should never					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155756 08/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7843 W JEFFERSON BLVD **COVENTRY MEADOWS** FORT WAYNE, IN46804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must provide routine and F0425 emergency drugs and biologicals to its SS=D residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. F 425 Pharmaceutical Svc -F0425 09/24/2011 Based on observation, record review, Accurate Procedures, RPH and interview, the facility failed to It is the practice of this facility to ensure correct labeling of medications provide pharmaceutical services for 2 of 10 residents observed during (including procedures that assure the medication pass, Residents #86 the accurate acquiring, receiving, dispensing, and administering of and #46. all drugs and biological) to meet the needs of each resident. Findings include: However, based on the alleged deficient practice the following 1. During observation of the was implemented: medication pass, with LPN #6, at 8:28 a.m., on 8/25/11, the LPN gave What corrective action(s) will resident #86 Cymbalta 30 milligrams be accomplished for those (mg) 2 capsules, by mouth. residents found to have been The directions on the label indicated affected by the deficient the resident was to receive 30 mg. of practice: Cymbalta, by mouth, daily. Resident's #86 and 46 The LPN indicated the Cymbalta had have clearly marked labels on been increased to 60 milligrams on

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLE	ETED
		155756	B. WIN			08/26/20	)11
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			JEFFERSON BLVD		
COVENT	RY MEADOWS				VAYNE, IN46804		
				<u> </u>	VATIVE, INTOOUT		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		er a label change had			medications with dose chang see MAR for directions.	ges to	
		d on the medication			see MAR for directions.		
	label. The LPN	N was then noted to			How will you identify other		
	place a sticker	which indicated a			residents having the potent	tial	
	direction chang	ge for the medication.			to be affected by the same		
					deficient practice and what		
	LPN #6 was of	served to give resident			corrective action will be tak		
	#46 3 units of I	•			<ul> <li>No other residents we</li> </ul>	-	
	insulin,100u/m	· ·			found to have been affected	•	
		y, at 8:37 a.m., on			the alleged deficient practice		
	l '	rections on the insulin			· Residents having		
					medication dose changes ha the potential to be affected b		
	· ·	tained the bottle of			alleged deficient practice.	y uic	
		ed to give 6 units of			· Licensed staff will be		
	Humalog insuli				in-serviced on putting direction	on	
	LPN #6 indicat	ed the resident used to			change label on the medicat	ion.	
	receive 6 units	of Humalog insulin,			Education will be provided by	y	
	but the order h	ad been changed, and			Staff Development		
	the resident no	w received 3 units of			Coordinator/Designee and		
	Humalog.				completed by September 24 2011.	,	
		e LPN was noted to			· All Medications were		
		on change sticker on			audited by nurse managers t	.o	
	the insulin box.	•			ensure they matched the		
		•		physician order			
	Davious of the	medication					
	Review of the r				What measures will be put	into	
		record for resident #46			place or what systemic		
		lumalog insulin was			changes you will make to		
	changed to 3 u	nits on 7/29/11.			ensure that the deficient practice does not recur:		
					· Licensed staff will be		
		interviewed, at 10:20			in-serviced on putting direction	on	
	a.m., on 8/26/1	1, and indicated if a			change label on the medicat		
	medication dos	sage was changed, the			Education will be provided by		
	nurse taking th	e order should either			Staff Development		
					Coordinator/Designee and		
						,	
	, · · · ·	the change and refer to			ZUTT.		
	nurse taking th request a new pharmacy, or p	e order should either label from the blace a sticker on the			Staff Development		
	Dottie to snow i	ine change and refer to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII	PLE CON			OATE SURVEY OMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155756	A. BUILDIN	IG	00	08/26/2	
		155756	B. WING			00/20/2	011
NAME OF F	PROVIDER OR SUPPLIER		I		DDRESS, CITY, STATE, ZIP CODE		
COVENT	RY MEADOWS				JEFFERSON BLVD AYNE, IN46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		Administration Record			Nurse mangers will modaily for medication changes		
for change.				correct labels.			
	0.4.05( )				· DNS is responsible to		
	3.1-25(e)				oversee compliance.		
					How the corrective action(s	.,	
					will be monitored to ensure	-	
					deficient practice will not re		
					i.e., what quality assurance		
					program will be put into pla	ıce:	
					A CQI monitoring tool called Medication Changes v	will be	
					utilized every week x 4, mon		
					3 and every other month x 3.	•	
					Data will be collected	•	
					DNS/Designee from 1 st and shifts and submitted to the C		
					Committee. If threshold is no		
					met, an action plan will be	•	
					developed.		
					Non-compliance with		
					facility procedure may result disciplinary action up to and	ın	
					including termination.		
					Compliance date: 9/24/201	1	
F0463	The nurses' statio	n must be equipped to					
SS=D	receive resident c						
		stem from resident rooms;					
	and toilet and bat						
		ervation, record review,	F0463	3	F 463 Resident Call System Rooms/Toilet/Bath	-	09/24/2011
	· ·	the facility failed to			NOUTION TOTIC (/ Datif		
	1	ght in a resident's room			What corrective action(s) w	rill	
	·	for 1 of 40 residents in			be accomplished for those		
	i the stage 1 sar	mple. (Resident #126)			residents found to have been	ən	
		lo:			affected by the deficient	ľ	
	Findings includ	ie:			<pre>practice:</pre>	ht	
					resident # 120 call lig		

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155756	A. BUI	LDING	00	COMPLETED 08/26/2011
		193730	B. WIN			00/20/2011
NAME OF 1	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE	
COVENI				1	JEFFERSON BLVD	
	TRY MEADOWS			FURIV	VAYNE, IN46804	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG		DATE
		view, with Resident			was fixed by Maintenance Supervisor on 8/22/11.	
		11, at 2:32 p.m., the			Supervisor on 0/22/11.	
		ht was tested for			How will you identify other	
	1 ' '	ning. The call light was			residents having the poten	tial
		did not light up over the			to be affected by the same	
		, and the resident			deficient practice and what	
		all light was not			corrective action will be tak	en:
		eek" and she had			<ul> <li>All residents have the potential to be affected by th</li> </ul>	<u> </u>
	reported this to CNA #9.				alleged deficient practice.	
	CNA #9 was in	iterviewed, at 2:33 p.m.,			· All maintenance staff	vill
	on 8/22/11, and attempted to test the				be educated on the procedu	
	call light, but it	did not work. The CNA			checking the call light system	
	indicated he ha	ad reported this last			when any malfunction is repo and after the repair has beer	
	week, and had	filled out a work order			completed to ensure call ligh	
	for the non-fun	ctioning call light.			system works properly. The	
	The Maintenar	nce Supervisor was			education will be conducted	by
	observed to te	st the call light, at 2:35			the Executive Director/Desig	
	p.m., on 8/22/1	I1, and indicated it was			and completed by September	er 24,
	not working. H	e indicated he had			2011.	
	gotten a work	order last week.			What measures will be put	into
	The maintenar	nce man repaired the			place or what systemic	
		ndicated the "tab" was			changes you will make to	
	_	e "duty station" so the			ensure that the deficient	
		vould not fit tightly.			practice does not recur:	:0
		<b>3</b> ,			<ul> <li>All Maintenance staff be re-educated on the proce</li> </ul>	l I
	Review of a ma	aintenance request,			of checking the call light syst	
		provided by the			when any malfunction is repo	
		Supervisor on 8/25/11,			and after the repair has beer	
		indicated the call button			completed to ensure call ligh	t
	· ·	l6's room was not			system works properly. Education will be provided b	,
	working.				Executive Director/Designee	
		oleted indicated			completed by September 24	
	8/20/11.				2011.	
					· All staff is being in-ser	viced
	3.1-19(u)(1)				by the Staff Development	
	<u> </u>					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155756		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 08/26/2011		
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE  7843 W JEFFERSON BLVD  FORT WAYNE, IN46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	REGULATION ON			Coordinator/Designee on the maintenance request system how to report maintenance problems. In-servicing will be completed by September 24 2011.  Executive Director is responsible to oversee compliance.  How the corrective action(swill be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plates A CQI monitoring tool called Call Light System will utilized every week x 4, mon 3 and quarterly x 2.  Data will be collected DNS/Designee from 1 st and shifts and submitted to the CC Committee. If threshold is not met, an action plan will be developed.  Non-compliance with facility procedure may result disciplinary action up to and	e the ecur, lice: be thly x by 1 2 nd QI		
				including termination.			
F0464 SS=E	These rooms mus ventilated, with no be adequately furn	rovide one or more rooms ident dining and activities.  t be well lighted; be well nsmoking areas identified; nished; and have sufficient odate all activities.		Compliance date: 9/24/201	1		

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DINC	00	COMPL	ETED
	155756		A. BUILDING B. WING			08/26/2011	
		<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					JEFFERSON BLVD		
COVENT	COVENTRY MEADOWS				VAYNE, IN46804		
				L	VATIVE, 11440004		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		ervation and interview,	F0	464	F 464 Requirements for Din	ing	09/24/2011
	the facility faile	d to ensure adequate			& Activity Rooms	. 4-	
	space for dinin	g in 1 of 5 dining rooms			It is the practice of this facility	-	
	observed for 2	6 of 42 residents who			provide a dining room that he sufficient space to accommo		
	ate their meals	in the main dining			all activities. However based		
	room.	3			the alleged deficient practice		
	1001111				following has been implemen		
	Finding include	ee:					
		<del> </del>					
	0 0/00/44	10.00			What corrective action(s) w	'ill	
		12:00 p.m., during			be accomplished for those		
	observation of the main dining room,				residents found to have be	en	
	residents were	seated at tables and			affected by the deficient		
	coming into the	e dining room. Staff			practice:	_	
	were assisting	in moving residents so			<ul> <li>The dining room table were moved on September 8</li> </ul>		
	other residents	could get to their			2011 to the exterior walls for		
		nd of the dining room			the 42 residents in the main	20 01	
	farthest from th	•			dining room to assure adequ	ate	
		the far end of the			space.		
		dicated 7 tables with a					
	_	dents seated at the			How will you identify other		
					residents having the potent	tial	
		ents already seated at			to be affected by the same		
		e observed to be			deficient practice and what		
	moved from the	e table so other			corrective action will be tak		
	residents could	d get through, and then			· All residents who eat i		
	taken back to t	heir table.			dining rooms have the poten be affected by the alleged	และเอ	
					deficient practice.		
	Observation on 8/25/11 at 12:00 p.m. indicated residents seated at tables at the far end of the dining room and being moved from the table so other				· All Nurses and Dining		
					Room managers will be educ	cated	
					on observing to ensure there		
					adequate space in the dining	I	
	. •				rooms and reporting any		
		d get to their table.			concerns to the Executive		
		were observed to be			Director. The education will	ре	
		en moved back to their			conducted by the Staff		
	table.				Development Coordinator/Designee and		
			1	l	Coordinator/Designee and		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SUR	VEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLETE	ED.	
		155756	B. WIN			08/26/2011	08/26/2011	
		<u> </u>	B. WIN		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
COVENTRY MEADOWS			7843 W JEFFERSON BLVD FORT WAYNE, IN46804					
	COVENTRY MEADOWS			<u> </u>	VATIVE, 11440004			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	, the state of the	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			OMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Interview with I	Resident #57 on			completed by September 24			
	8/25/11 at 12:3	0 p.m. indicated he			2011.			
	always has tro	uble getting into the			NA/Ib a A company and III be a compa			
	· •	his electric wheelchair.			What measures will be put	into		
	. •	ther residents have to			place or what systemic			
					changes you will make to ensure that the deficient			
		n get to his table. The			practice does not recur:			
		ted it was like this			All Nurses and Dining			
	everyday.				Room manager will be educated	ated		
					on observing to ensure there			
	On 8/26/11 at 8	3:50 a.m. interview with			adequate space in the dining			
	the Administrator indicated he had never had complaints from residents				rooms and reporting any			
					concerns to the Executive			
		ding in the main dining			Director. The education will	be		
		ministrator indicated he			conducted by the Staff			
					Development			
		the Dietary Manager			Coordinator/Designee and			
	1	y could re-arrange the	2011.		completed by September 24	'		
	tables.				Dining room managers	s are		
					responsible for monitoring al	I		
	Interview on 8/	26/11 at 9:00 a.m. with			dining rooms at all three mea	I		
	the Dietary Ma	nager indicated last			for adequate space for all			
	week she had	moved the tables on			residents.			
	the end of the	dining room at an angle			<ul> <li>Executive Director is</li> </ul>			
		d some tables down but			responsible to oversee			
					compliance.			
		keep moving them				,		
	back.				How the corrective action(s			
					will be monitored to ensure			
	3.1-19(w)				deficient practice will not re	<b>I</b>		
					i.e., what quality assurance program will be put into pla	<b>I</b>		
					A CQI monitoring tool	ice.		
					called Adequate Space will b	e		
					utilized every week x 4, mon	<b>I</b>		
					3 and quarterly x 2.	´		
					· Data will be collected	by		
					DNS/Designee from 1 st and	I		
					shifts and submitted to the C	QI		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155756	B. WING		08/26/2011	
NAME OF F	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	-	
00) (5) 17	·D./ ME A D O.//O		<b>I</b>	V JEFFERSON BLVD		
COVENT	RY MEADOWS		FORT	WAYNE, IN46804		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	Committee. If threshold is no	DATE	
				met, an action plan will be developed.  Non-compliance with facility procedure may result disciplinary action up to and including termination.		
F0514 SS=A	each resident in according professional stand complete; accurate accessible; and sy.  The clinical record information to identhe resident's asseand services provipreadmission screstate; and progress Based on obseand interview, the ensure document new physician of change was resident (#86), related to meal (Resident #82) reviewed for clining sincluded in the progression of the profession	rvation, record review, he facility failed to entation regarding a order for a medication adily accessible, for 1 and for 1 resident consumption of 40 residents nical records in the	F0514	F 514 Clinical Records  It is the practice of this facility to ensure there is accommentation regarding a rephysician order for a medical change and that meal consumption is documented accurately for every resident However, based on the alleg deficient practice the following has been implemented:  What corrective action(s) we be accomplished for those residents found to have be affected by the deficient practice:  Resident #86 has clear	eurate new tion ged ng vill en	
	milligrams, 2 c	•		marked labels on medication	· I	

li ´		i i		X3) DATE SURVEY			
		IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155756	B. WIN	G		08/26/2011	
NAME OF PROVIDER OR SUPPLIER			-		DDRESS, CITY, STATE, ZIP CODE		
			7843 W JEFFERSON BLVD				
COVENTRY MEADOWS				FORT V	VAYNE, IN46804		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	DEFICIENCY)	DATE	
	milligrams). Th				with dose changes to see Ma for directions.	AR	
	1 -	cated to give Cymbalta			Resident #82 meal		
	30 milligrams,	by mouth, daily.			consumption record will be		
	The LPN indicate	ated the medication			monitored daily.		
	had been incre	eased to 60 milligrams			•		
	on 8/19/11, be	cause of a pharmacy			How will you identify other		
	recommendati				residents having the potent	tial	
					to be affected by the same		
	The resident re	ecord was reviewed, at			deficient practice and what	<b>I</b>	
	9:30 a.m., on 8/25/11, and physician orders for August, 2011, indicated Cymbalta 30 milligrams 1 capsule, by				corrective action will be tak	(en:	
					No other residents we	re	
					found to have been affected	·	
					the alleged deficient practice		
	mouth, daily.	f Nursing Condoos			All residents with		
		f Nursing Services			medication order changes ha		
	1 '	erviewed, at 9:48 a.m.,			the potential to be affected b	y the	
	· ·	d indicated she was			deficient practice.  All residents have the		
	1	the order to increase			potential to be affected by		
	the Cymbalta t	o 60 milligrams daily.			inaccurate meal consumption	n	
					documentation.		
		DNS was interviewed,			· Licensed staff will be		
	at 10:12 a.m.,	on 8/25/11, and			re-educated on the proper	. [	
	indicated she h	nad found the			labeling of medication change	•	
	pharmacy reco	ommendation, dated			alert staff that dose changes been made. Education will be		
	8/18/11, for inc	reasing the Cymbalta			provided by Staff Developme	<b>I</b>	
	•	36 from 30 milligrams to			Coordinator/Designee and		
		The Assistant DNS			completed by September 24	,	
	indicated she f				2011.		
	recommendation in medical record office, but said it should have been				· All nursing staff will be	;	
					re-educated on the proper		
	1	resident's chart, as a			documentation of meal consumption intake policy by	,	
	1 '	•			Staff Development Coordina		
	physician order. She indicated the pharmacy used the pharmacy				and Dietary Manager by		
	1 '				September 24, 2011.		
	1	on sheet as the					
	1 ' '	ler, and indicated she			What measures will be put	into	
	didn't know wh	y it was in medical			place or what systemic		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		A. BUILDING	00	COMPI 08/26/2	LETED		
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE  7843 W JEFFERSON BLVD FORT WAYNE, IN46804				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	D BE	(X5) COMPLETION DATE	
iau	record office, a	s it should have been esident's record.	iau	changes you will make ensure that the deficier practice does not recurved:  Licensed staff will re-educated on the proplabeling of medication chalert staff that dose charbeen made. Education verovided by Staff Develor Coordinator/Designee by September 24, 2011.  All nursing staff were-educated on the proper documentation of meal	be er nanges to nges have vill be opment		
				consumption intake police Staff Development Coors and Dietary Manager by September 24, 2011.  Nurse Managers are responsible to oversee compliance.  How the corrective active will be monitored to en	dinator are on(s) sure the		
				deficient practice will n i.e., what quality assura program will be put into  A CQI monitoring called Meal Consumptio utilized every week x 4, 3 and quarterly x 2.  A CQI monitoring called Medication Chang utilized every week x 4, 3 and quarterly x 2.  Data will be colled DNS/Designee from 1 st	tool monthly x tool ges will be monthly x		
				shifts and submitted to the Committee. If threshold met, an action plan will be	ne CQI is not		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155756		(X2) MULTIPLE (A. BUILDING B. WING	00	li i	e survey Pleted <b>/2011</b>	
NAME OF PROVIDER OR SUPPLIER  COVENTRY MEADOWS			7843	T ADDRESS, CITY, STATE, ZIP O W JEFFERSON BLVD WAYNE, IN46804	CODE	
PREFIX (EACH	H DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
				developed.  Non-compliar facility procedure madisciplinary action upincluding termination	ay result in p to and	
#82 wa p.m. D not limit diabete (difficult)  The care effects dated 4 ordered replace consum  The "Di 4/27/11 receiving thick lique fed by see the resi and sweet by staff.  On 8/25	s reviewing systems to to, and a systems of high and a staff.  The plan is the systems of high and a purple systems of the sys	for at risk for adverse or low blood sugar, indicated "diet as or intakes and offer or less than 75%  rogress Notes," dated ted Resident #82 was eed diet with nectar d that the resident is  for mechanically ted 7/11/11, indicated d a history of chewing g difficulties and is fed		Compliance date: 9	9/24/2011	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	li i		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155756	A. BUILDING	00	COMPLETED 08/26/2011
		100700	B. WING		00/20/2011
NAME OF F	PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE	
COVENTRY MEADOWS				V JEFFERSON BLVD WAYNE, IN46804	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE DATE
	room for lunch.				
	At 12:35 p.m., t	the resident had			
	consumed less	than 50% of lunch.			
	At 12:37 a.m., a	all staff in dining room			
		ling residents and			
	_	all residents back to			
	their rooms.				
	The "Food/Fluid	d Intake Record,"			
		011, listed Resident			
	_	consumed 100% of			
	lunch on 8/25/1				
	An interview wa	as conducted with QMA			
		at 10:27 a.m. During			
		he indicated Resident			
		50% percent of his			
		1 and drank his			
	•	rther indicated he was			
		had to keep waking			
	•	so indicated nursing is documenting meal			
	consumption.	documenting mean			
	consumption.				
	3.1-50(a)(2)				